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SB 312

MHA AN ASSOCIATION OF MONTANA HEALTH CARE PROVIDERS

Testimony on SB 312
Before the House Business and Labor Committee

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The argument for SB 312 is that hospitals are using their economic clout to pressure, limit or otherwise control physicians' ability to practice medicine. This simply isn't true.

This bill arises because the business world of health care has changed drastically in the past few years. In today's health care world, hospitals and physicians alike are trying to navigate an increasingly complex web of business and insurance arrangements.

It's not uncommon for physicians to compete directly with not-for-profit, community hospitals. This competition comes from physician-owned, for-profit surgery centers, specialty clinics, imaging centers and other facilities. The competitors are becoming more numerous and the competition more heated.

Current economic incentives encourage physicians and others to carve out specific, well paid, services away from the community hospital. Physician ownership arguably gives physicians an incentive to refer patients to their facility.

In order to refer patients whose needs exceed the services offered at the physician-owned facility, or to transfer more intense or emergency cases to the hospital, these same physicians also often want privileges to practice at the local non-profit, community-based hospital.

Several significant issues emerge when a physician wishes to both practice at the hospital and compete with the hospital. Hospitals face a financial threat caused by having profitable services diverted away from the hospital, leaving the facility with unprofitable services.

Hospitals rely on profitable services to provide a cross-subsidy needed to offer unprofitable services, such as emergency room and psychiatric care

Physicians with a conflict of interest may wish to continue to participate in strategic planning at the hospital or be involved in making decisions about issues that involve their competing enterprises.

The hospital may not be able to fulfill its community mission due to the financial hardship caused by competition. A competing physician that engages in "cherry-picking" patients – referring the insured, paying patients to their own facilities while leaving the uninsured or charity care patients to the hospital – can impose a substantial financial burden on the hospital.

Enactment of SB 312 means hospitals are limited in the measures they can take to address their legitimate concerns. SB 312, as amended, allows a physician to access the medical staff processes, but allows the hospital to limit physician involvement in decision-making when a conflict exists.

But SB 312 continues to forbid the hospital to act to address conflicts of interest that may harm the hospital or its patients. SB 312 also bars the hospital from refusing privileges to competing physicians, even when the hospital's financial security or safety net services are threatened.

Finally, SB 312 creates a legal right to sue the hospital if the physician believes that the hospital is interfering with their practice.

SB 312 began as a bill that tied the hands of the hospital board and management when the issue involved physician competition. That is, the bill was about what you can't do. With significant amendments, the bill now provides a few things a hospital can do, but some important issues remain.

Due to the amendments added to the bill in the Senate, hospitals are still barred from several activities that are considered to be economic credentialing. The amendments addressed some of our concerns:

- Hospitals may require physicians to provide enough care to allow the Joint Commission on Accreditation of Health Care Organizations (JCAHO) reviews or for evaluation of the physician's performance.;
- Hospitals can limit medical staff membership or staff privileges as required by its own bylaws;
- A hospital can limit a physician from decision-making positions when a conflict of interest exists;
- The definition of economic credentialing was amended to better delineate what is, and what is not, meant by economic credentialing; and
- The remedy for violating the statute was amended to remove state sanctions in favor of court action.

These amendments addressed some, but not all of our concerns. Among issues that remain are:

- Hospitals are barred from acting to address conflicts of interest that, in the hospital's judgment, adversely affect the hospital's patients;
- On page 1, line 23, the hospital may not require physician's to participate in any particular health plan. This means that hospital patients might find themselves receiving care from physicians that are outside of the health plan's insurance network; and
- A hospital is not able to sanction physicians that engage in cherry-picking patients. By cherry-picking we mean physician referral of well insured patients to their own facilities and referring the uninsured or impoverished patients to the hospital.

Section 6 of the bill, page 4, line 13, added a 2-year sunset provision to the bill. SB 312 is a companion bill to SJ 15 and the issues we raise are the subject of further deliberation by an interim legislative committee.

Conclusion

SB 312 is not perfect legislation. While we prefer not enacting SB 312, the bill appears to be a statute that we can live with while the issue undergoes further evaluation by the legislature.